History and Context

For a review of the history and purpose of these reports, the reader is referred to the "New TDO Exception Reporting Data Overview" document dated January 2015, which is available on the Department of Behavioral Health and Developmental Services (DBHDS) website at the following link: http://www.dbhds.virginia.gov/library/document-library/omh-new-tdo-exception-reporting-data-overview.pdf

This document is the sixth monthly report of data[1] collected to date from Community Services Boards (CSBs) and regions[2] for fiscal year 2015. The following sections contain the summaries and graphs of the monthly data reported to DBHDS through December 2014. Counts of events are presented for each month and for the state fiscal year (FY) to date for ease of comparison and trend analysis.[3] Additionally, certain high risk events are reported separately by CSBs, on a case-by-case basis as they occur. These involve individuals who are evaluated and need temporary detention, but are not detained for any reason. There were three such events in the December 2014 reporting period.

Each of these events triggers submission of an incident report to the DBHDS Quality Oversight Team[4] within 24 hours of the event. The reports describe the incident and proposed actions to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality Oversight Team reviews the incident report and actions of the CSB for comprehensiveness and sufficiency, and responds accordingly if additional follow up is needed. CSBs continue to update DBHDS until the situation has resolved and follow-up actions are implemented.

Of the three events reported in December, one was an individual who eloped from the hospital emergency department following assessment, another was an individual with complicated medical needs that delayed psychiatric hospitalization, and the last involved an individual who was mistakenly released by law enforcement. In all of these cases a TDO was ultimately executed and the individual hospitalized for psychiatric care. Additional detail on each of these cases can be found in Appendix D, page 21.

Graph 1. Emergency contacts statewide

Emergency contacts are events requiring any type of CSB emergency service involvement or intervention. There were 40,873 emergency contacts reported statewide during the month of December, which is a 20% increase from November. Graph 1, below, displays the statewide number of emergency contacts for July through December, and shows and a general trend upward for this period. Regional data is displayed

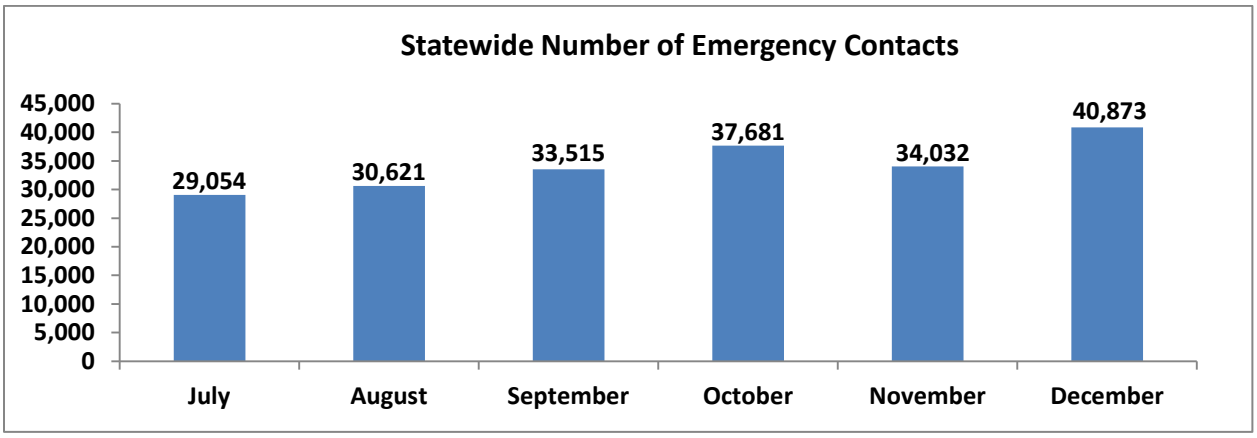
[1] See Appendix A for complete detailed listing of these definitions.

[2] There are 39 Community Services Boards and 1 Behavioral Health Authority in the Commonwealth, referred to in this report as CSBs. See Appendix B for a complete listing of CSBs within each of the seven regions.

[3] In addition, data is reported both statewide and by region in the report and in Appendix C.

[4] The Quality Oversight Team includes the DBHDS Medical Director, Assistant Commissioner for Behavioral Health, Director of Mental Health, and MH Crisis Specialist.

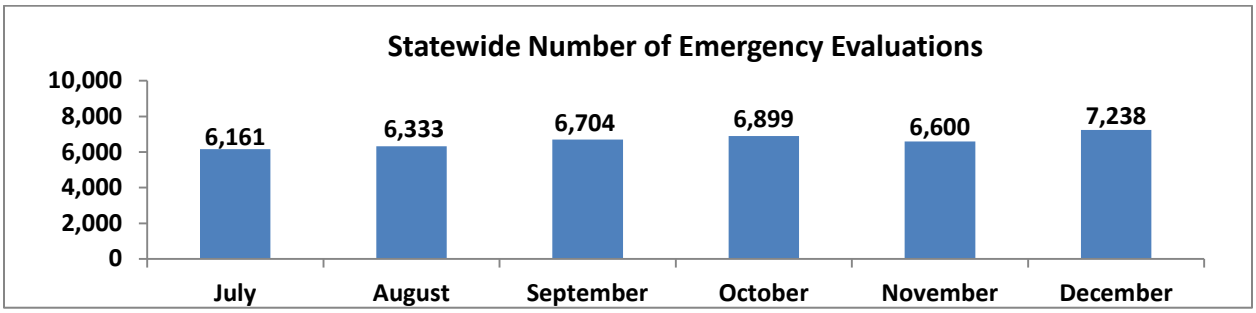
in graph 1a and table 1 in Appendix C, page 12. The largest regional increase was in Region 5 with a 62% increase in contacts over the previous month, followed by Region 7 (19% increase), Region 1 (17% increase), Region 3 (13% increase) and Region 4 (4% increase). Regions 2 and 6 experienced a slight decrease (.07% and 4% decreases, respectively) in emergency contacts in December. The steady overall increase in the number of emergency contacts for the first six months of FY 2015 is most likely attributed to refinements in data gathering procedures at the local level and clarification of this data definition by DBHDS in November, 2014. No CSB or region was able to identify any other events or actions that directly related to the observed increase in the volume of emergency contacts during this time period.



Graph 2. Emergency evaluations statewide

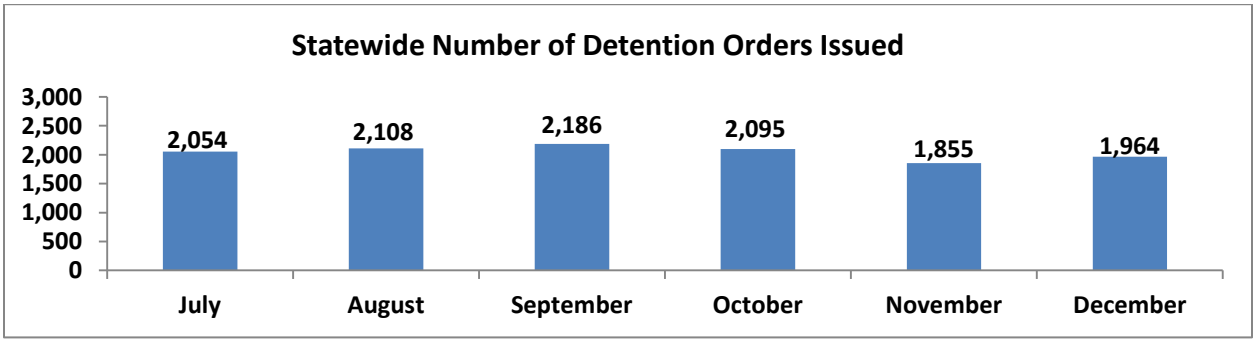
Emergency evaluations are comprehensive in-person clinical examinations conducted by CSB emergency services staff for individuals who are in crisis (including evaluations conducted electronically by two-way video and audio communication). The total number of emergency evaluations statewide in December was 7,238. This is an increase of about 10% from November, continuing a general trend upward since July (Graph 2). Regions 1, 4, 5 and 7 each reported increases in evaluations over the previous month. The increase in Region 1 was slight (5%), while the increase in Region 4 was 11%. Region 7 reported a 26% increase and Region 5 reported a 49% increase, which is well outside the trend of the other regions. Some of this variability may be attributed to the above-referenced refinements in data definitions and data gathering. For example, pre-hearing evaluations were not being consistently reported in prior months as emergency evaluations, especially in Region 5. It should also be noted that regions 4, 5, and 7 each reported significant decreases in emergency evaluations in November, and the December data for Regions 4 and 7 are still below their October figures. Regional data is shown in graph 2a and table 2 in Appendix C, page 13. [5]

[5] Figures for emergency contacts, emergency evaluations, and TDOs that are reported here and in subsequent pages of this report may represent duplicated (i.e., not mutually exclusive) counts of individuals because an individual may have made contact, or been evaluated or detained, on more than one occasion and could therefore be included two or more times in any of these categories.



Graph 3. TDOs issued statewide

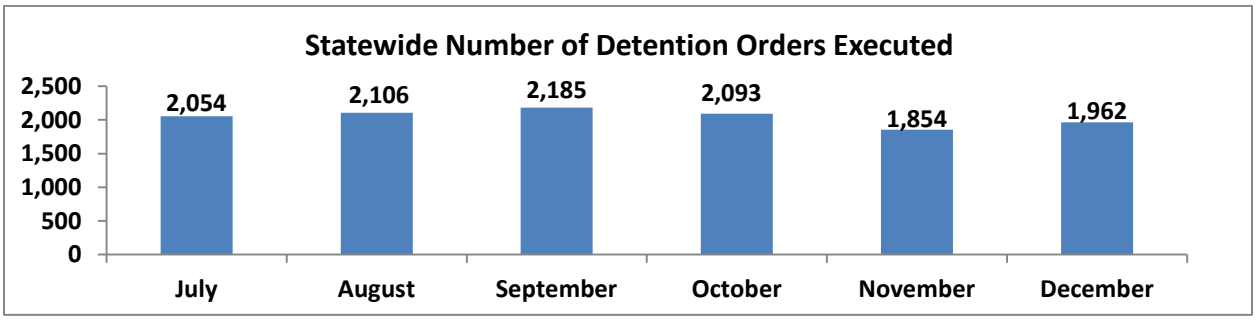
A TDO is issued by a magistrate after considering the findings of the CSB evaluation and other relevant evidence, and determining that the person meets the criteria for temporary detention under § 37.2-809 or § 16.1-340.1. A TDO is executed when the individual is taken into custody by the officer serving the order. In December, there were 1,964 TDOs issued (Graph 3), and 1,962 TDOs executed (Graph 4). Graph 3a and table 3 (page 14) and graph 4a and table 4 (page 15), display this data by region in Appendix C. This is an increase of 109 TDOs issued over November, representing an increase of approximately 6%. However, the December figures for TDOs issued and TDOs executed are the second lowest, after November, of the year to date. All regions saw an increase in the number of TDOs issued and executed in December except Region 6, which reported the lowest monthly figure for TDOs issued and executed of the year to date for that region. **About 73% of the emergency evaluations in December (5,274 of 7,238) did not result in a TDO.**



Graph 4. TDOs executed statewide

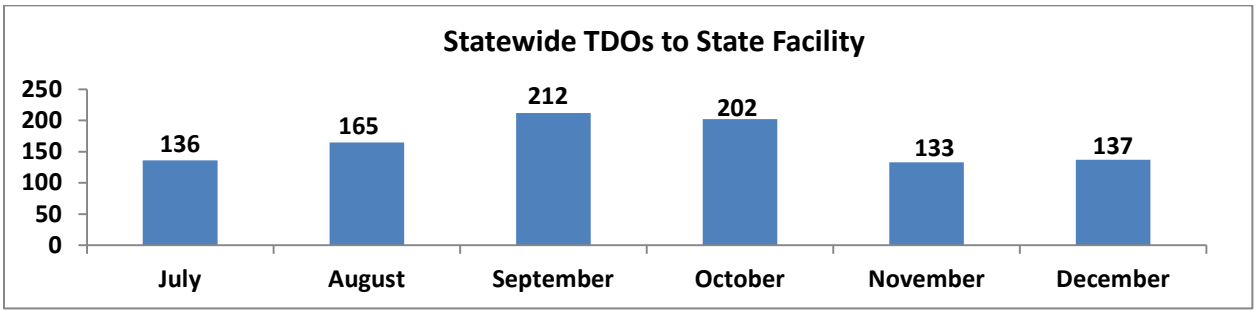
There were two temporary detention orders issued but not executed during the month of December. Both TDOs were issued for the same individual during a single event, and the incident was reported to the DBHDS Quality Oversight Team as a high-risk event. The individual initially presented at a local emergency department for voluntary mental health care. The individual was examined and a TDO was issued, but the individual left the emergency department prior to execution of the TDO. Despite an extensive search by law enforcement, the individual could not be found, and the TDO expired. A second

TDO was obtained and again the TDO expired before the individual was located. When the individual was finally located an ECO was issued, the individual was reassessed by the CSB and a third TDO was issued and executed. This case is summarized in Appendix D, case 3.



Graph 5. TDO admissions to a state hospital statewide

Of the 1,962 TDOs executed in December, 137 (<7%) resulted in the individual being admitted to a state hospital [6] (Graph 5). This is an increase of 3% from November. There continues to be variance among regions in the number of state hospital TDO admissions, as shown in Graph 5a and table 5 in Appendix C, page 16. Region 6, for example, had a 36% decrease from November in the number of TDO admissions to a state hospital, while Region 3 had a 25% increase and Region 7 had a 44% increase from the previous month. This variance reflects each region's unique resources and protocols as well as access to community psychiatric facilities and geographic details. DBHDS is closely tracking state hospital usage and is working with the regions to minimize usage of state facilities for temporary detention through increased use of community psychiatric resources, alternatives to hospitalization, and more explicit utilization protocols for state hospitals. DBHDS also closely monitors use of the Psychiatric Bed Registry as a search tool as well as to track any trends regarding the use of local resources.

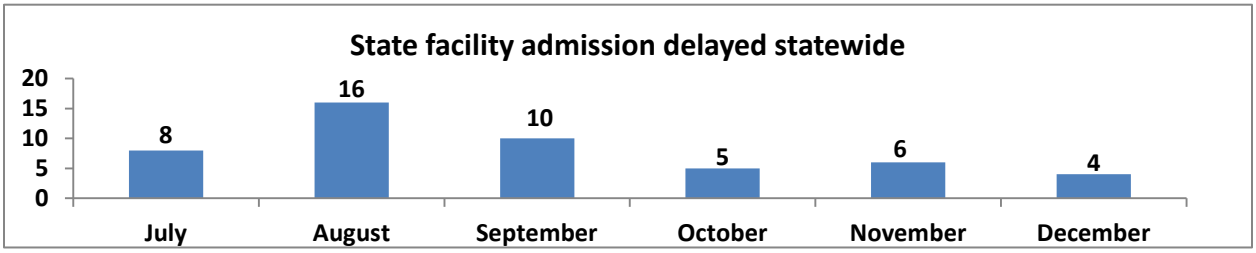


Graph 6. State hospital admission delayed statewide

In December, there were four occasions when the state hospital was deemed the "hospital of last resort" but admission could not be accomplished before the ECO time period expired (Graph 6). The delays in

[6] Source: DBHDS AVATAR admitting CSB data

three of these cases were due to the individuals' more immediate medical testing and treatment needs, and in one case, having to wait for an after-hours Child Protective Services (CPS) worker to arrive to petition for the TDO on a minor. In two instances, delays were aggravated by technical difficulties with wireless fax transmissions between providers. All of these individuals were ultimately admitted to the state psychiatric hospital. The four delayed admissions in December are a 33% decrease from November, and continue the overall downward trend since August. DBHDS has directed the CSBs which encountered technical difficulties with their fax communications to work with their service partners (i.e. emergency departments and state hospitals) to develop alternate communication protocols which will provide timely communication when technology is not functioning properly or is unavailable. Graph 6a and table 6 displays this data by region in Appendix C, page 17. Regions 2, 3, 4, 6 and 7 did not experience this type of event in December.



Graph 7. TDO executed after ECO expired statewide

Amendment added 1/12/2017)

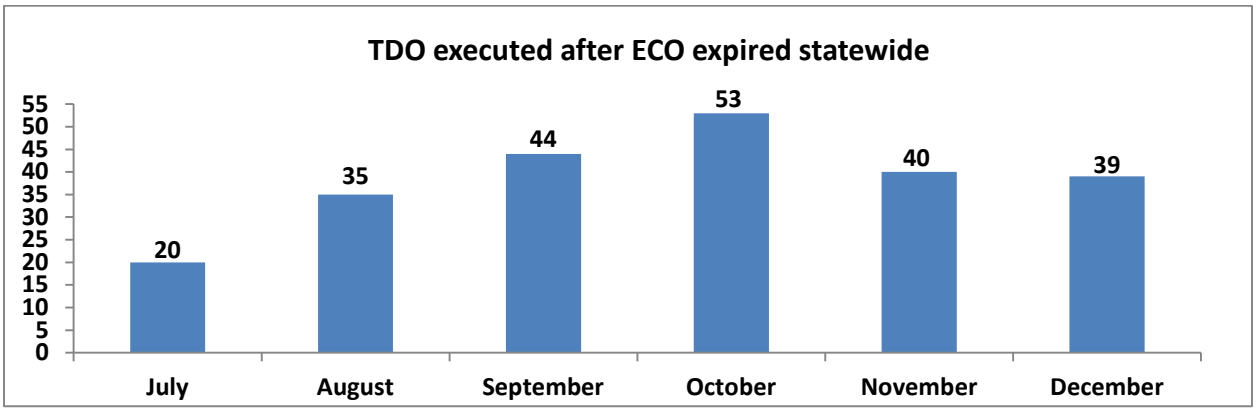
Upon further analysis of the TDO Exception Reports issued September 2014 through June 2015, PPR7 and Blue Ridge Behavioral Healthcare, the CSB serving this region, initially reported time of issuance of the TDO versus execution of the TDO, which is the format that all other PPR regions used to calculate outcomes. This made the comparison between PPR&s data and other regions invalid. Please refer to the chart below for corrections to the data:

Month	ORIGINIALLY REPORTED # of incidents in which TDO was executed after the ECO expired in original report	CORRECTIONS TO DATA # of incidents in which TDO was obtained prior to the ECO expiring but not executed before the ECO expired
September 2014	25	3
October 2014	21	3
November 2014	18	3
December 2014	22	1
January 2015	20	6
February 2015	19	4
March 2015	23	1
April 2015	22	2
May 2015	37	5
June 2015	21	5

In December, there were 39 (<2%) reported cases where a TDO was issued but not executed until after the ECO period had ended (Graph 7). This is a 2% decrease from November, continuing a steady downward trend from October. Since July, several CSBs have sought clarification from DBHDS and received additional direction on reporting this type of event. The decrease reported in December may reflect, in part, changes in CSB reporting practices resulting from DBHDS guidance. The majority of these cases (28 of them) involved waiting for law enforcement to execute TDOs that were issued prior to the expiration of the ECO time period. In seven more cases, law enforcement declined to execute the TDO until medical treatment was completed. In 35 of these cases, the individuals were maintained safely in an emergency department, either locked (19) or unlocked (16), with law enforcement or security presence and ultimately admitted to a psychiatric hospital without any lapse in custody. The remaining individuals were maintained safely within their private homes (2), a therapeutic assessment center (1), and an adult detention center (1) with law enforcement presence. These individuals were also ultimately admitted to a psychiatric hospital without any loss of custody. Providers continue to utilize physically secure environments (such as a locked emergency department or secure assessment sites) as well as law enforcement officers, to maintain custody.

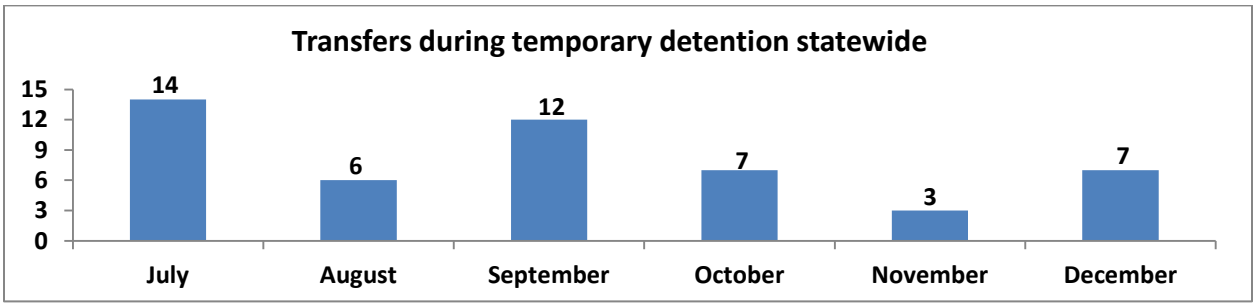
Graph 7a and table 7 display this data by region in Appendix C, page 18. Regionally, these cases continue to be highly variable in terms of frequency. Region 2, for example, has reported monthly total cases of 3, 1, 12, 3, 9, and 1 since July. Region 4 did not experience this type of event in December. Regions 5 and 7 continue to have the highest total numbers of these cases, with 10 and 23, respectively, for December, and 56 and 109 for the six-month period beginning in July. DBHDS has provided technical assistance to the CSBs in Region 5 and recommended that the Regional Manager and CSBs convene key stakeholder agencies in a discussion about improving the timeliness of TDO execution.

Region 7 continues to have the greatest number of these cases. This region reported 123 TDOs issued and executed during December, 2014, and 18% were executed after the ECO period expired, a figure that is similar to November. The time between issuance of the TDO and time of TDO execution ranges from 35 minutes to 11 hours and 40 minutes with a mean of 3 hours and 27 minutes. DBHDS has met with the Executive Director and Clinical Director of Blue Ridge Behavioral Health (BRBH), the CSB serving the five metropolitan Roanoke area jurisdictions, to develop a quality improvement strategy to identify the primary drivers of these cases and to engage key partners on ways to reduce these delays. To date these efforts have been targeted to the Carillion Emergency and Police Departments, the Roanoke City Sheriff and Magistrate, and Catawba Hospital. DBHDS maintains regular monitoring of this effort.



Graph 8. Transfers during temporary detention statewide

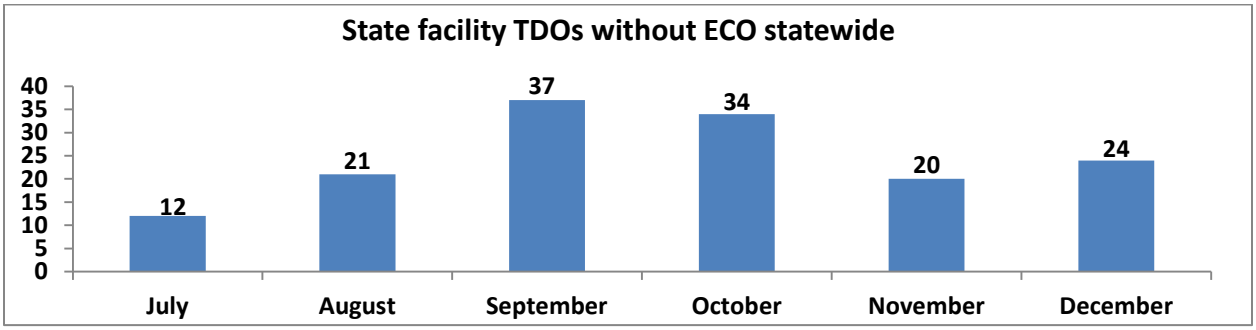
Section § 37.2-809.E. of the *Code of Virginia* allows an individual to be transferred during the period of detention from one temporary detention facility to another more appropriate facility in order to address an individual's security, medical or behavioral health needs. This procedure was used 7 times (7 transfers of 1,962 executed TDOs, or <1%) during December (Graph 8). In five cases, the transfer was from a state facility to a private facility or residential crisis stabilization unit, and two transfers were from one private facility to another. These seven cases are a 133% increase from November, but reflect a focus on accessing the most appropriate temporary detention placement for the individual. Graph 8a and table 8 displays this data by region in Appendix C, page 19. Regions 3, 5, 6 and 7 did not report any of these transfers in December.



Graph 9. State hospital TDOs without ECOs statewide

As the "hospital of last resort", DBHDS facilities admit individuals who need temporary detention for whom no alternative placement can be found, whether or not the individual is under an ECO. CSBs report each "hospital of last resort" admission where no ECO preceded, along with how many alternate facilities were contacted and the reason(s) for the inability to locate an alternate facility. In December, there were 24 such admissions to a state facility, which is a 20% increase from November (Graph 9). Region 3 continues to report the most such admissions since July. A total of 183 contacts were made for an average of about eight alternate facilities contacted in each of these 24 instances. Ten of the admissions were for specialized care due to the individual's age (under 18 or aged 65 and older) and ten more

admissions were due to lack of capacity at the alternate facilities contacted. Other reasons for these admissions included diagnosis of intellectual or developmental disability; medical needs beyond the capability of the alternate facilities contacted; and aggressive behaviors not manageable in the alternative facilities contacted. DBHDS monitors the Psychiatric Bed Registry daily for updating by facilities regarding their bed availability as well as the comments entered by users seeking a bed. Graph 9a and table 9 displays this data by region in Appendix C, page 20.



Discussion:

To enhance consistency and accuracy of CSB reporting, DBHDS has worked continuously since July with individual CSBs and regions to identify data elements that are not clearly or consistently understood, and to address any improper or inconsistent reporting. In November 2014, DBHDS issued comprehensive clarifying revisions to both the monthly reporting forms and data definitions. DBHDS has also established a workgroup consisting of CSB Executive Directors, CSB Service and Data Managers, and DBHDS representatives to further strengthen the reporting and quality oversight process. One objective of this group is to ensure that this data is consistently used by CSBs and regions to identify utilization trends, policy or practice issues, technical assistance needs and opportunities for quality improvement at the agency, regional, and statewide levels.

At the state level, these data enable DBHDS to continue its ongoing system monitoring and performance improvement efforts, which support a well-functioning and responsive emergency system. DBHDS, CSBs, and local emergency service partners communicate regularly and timely to improve local care coordination, eliminate system gaps and clarify agency and staff roles in the emergency response system. Lastly, DBHDS continues to convene regular and frequent stakeholder meetings at the state level to share this data, communicate directly about problem issues, and jointly develop and implement effective operational improvements.

APPENDIX A

Data Elements Reported Monthly by CSB/BHAs

Each CSB/BHA reports four data factors on volume to the region:

1. Emergency contacts: The total number of calls, cases, or events per month requiring any type of CSB emergency services involvement or intervention, whether or not it is about emergency evaluation, and regardless of disposition. Calls seeking information about emergency services, potential referrals, the CSB, etc., should be counted if the calls come to emergency services (e.g., through the crisis line) and require emergency services to respond. Any other contacts to emergency services from individuals, family members, other CSB staff, health providers or any other person or entity, including contacts that require documentation in an individual's health record, should be counted as emergency contacts. Any contacts that precipitate an intervention or emergency response of any kind should be counted as emergency contacts.
2. Emergency Evaluations: Emergency evaluations are clinical examinations of individuals that are performed by emergency services or other CSB staff on an emergency basis to determine the person's condition and circumstances, and to formulate a response or intervention if needed. This figure is the total number of emergency evaluations completed, regardless of the disposition, including evaluations conducted in person or by means of two-way electronic video/audio communication as authorized in 37.2-804.1.
3. Number of TDOs Issued: TDOs are issued by a magistrate.
4. Number of TDOs Executed: TDOs are executed by law enforcement officers. A TDO is executed when the individual is taken into custody by the law enforcement officer serving the temporary detention order. It is possible under some circumstances that a TDO issued by a magistrate may not be executed for some reason.

Each CSB/BHA also reports six additional data elements:

1. Cases where the state hospital was used as a “last resort”: Under the new statutory procedures effective July 1, 2014, when an individual is in emergency custody and needs temporary detention, and no other temporary detention facility can be found by the end of the 8-hour period of emergency custody, then the state hospital shall admit the individual for temporary detention. Each region's Regional Admission Protocol describes the process to be followed for accessing temporary detention facilities and for accessing the state hospital as a "last resort" facility for temporary detention.
2. Cases where a back-up state hospital was used: Under some circumstances, the primary state hospital may not be accessible as the "last resort" temporary detention facility when needed at the end of the 8-hour ECO period, and a back-up state hospital will need to admit the individual as a "last resort" admission.
3. Cases where the state hospital is called upon as the "last resort" for temporary detention, but admission cannot occur at the 8-hour expiration of the ECO because of a medical or related clinical issue that must be addressed (i.e., medical condition cannot be treated effectively in the state hospital, person is not medically stable for transfer to state hospital, required medical testing is not yet completed, etc.).

4. Cases where a TDO may be issued by a magistrate while the person is in emergency custody, but the TDO will not be executed until after the 8-hour period of emergency custody has expired. Under the new statutes, if this scenario should occur, the individual may not be released from the CSB's custody until the TDO is executed.
5. Cases where a facility of temporary detention is transferred post-TDO: a CSB is allowed to change the facility of temporary detention for an individual at any time during the period of temporary detention pursuant to 37.2-809.E.
6. Cases where there is no ECO, but TDO to state hospital as a “last resort”: These are instances when an individual who is not in emergency custody (i.e., no ECO) is deemed to need temporary detention. If no suitable alternative facility can be found, state hospitals must serve as the "last resort" temporary detention facility in these cases.

Note: For the six data elements immediately above, associated descriptor information is reported as well.

APPENDIX B

Partnership Planning Region	Community Services Board or Regional Behavioral Health Authority
1 Northwestern Virginia	Horizon Behavioral Health Services Harrisonburg-Rockingham CSB Northwestern Community Services Rappahannock Area CSB Rappahannock-Rapidan CSB Region Ten CSB Rockbridge Area Community Services Valley CSB
2 Northern Virginia	Alexandria CSB Arlington County CSB Fairfax-Falls Church CSB Loudon County CSB Prince William County CSB
3 Southwestern Virginia	Cumberland Mountain CSB Dickenson County Behavioral Health Services Highlands Community Services Mount Rogers CSB New River Valley Community Services Planning District One Behavioral Health Services
4 Central Virginia	Chesterfield CSB Crossroads CSB District 19 CSB Goochland-Powhatan Community Services Hanover CSB Henrico Area Mental Health & Developmental Services Board Richmond Behavioral Health Authority
5 Eastern Virginia	Chesapeake CSB Colonial Behavioral Health Eastern Shore CSB Hampton-Newport News CSB Middle Peninsula-Northern Neck CSB Norfolk CSB Portsmouth Department of Behavioral Healthcare Services Virginia Beach CSB Western Tidewater CSB
6 Southern	Danville-Pittsylvania Community Services Piedmont Community Services Southside CSB
7 Catawba Region	Alleghany Highlands CSB Blue Ridge Behavioral Healthcare

APPENDIX C

Graph 1a. Emergency contacts by region

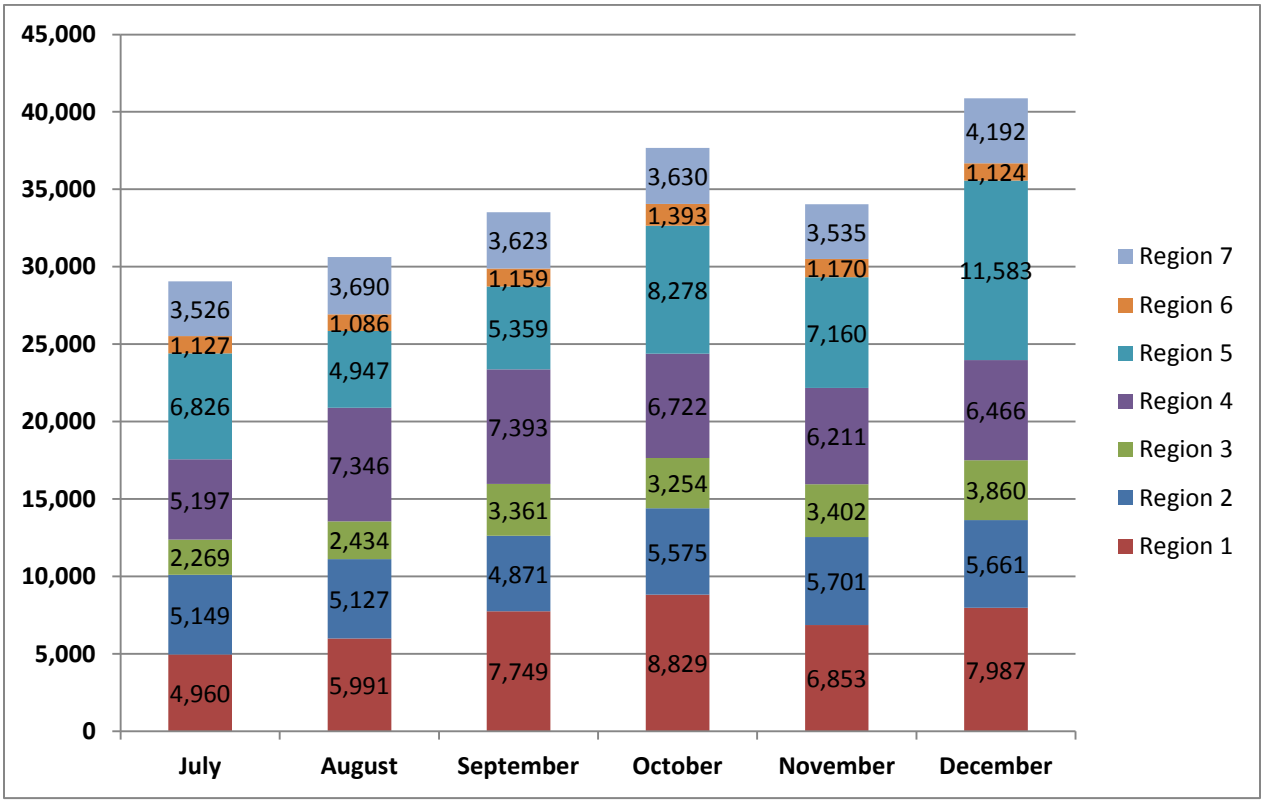


Table 1. Number of emergency contacts (corresponds with graph 1a)

Region	July	August	September	October	November	December	Total
Region 1	4,960	5,991	7,749	8,829	6,853	**7,987**	**42,369**
Region 2	5,149	5,127	4,871	5,575	5,701	**5,661**	**32,084**
Region 3	2,269	2,434	3,361	3,254	3,402	**3,860**	**18,580**
Region 4	5,197	7,346	7,393	6,722	6,211	**6,466**	**39,335**
Region 5	6,826	4,947	5,359	8,278	7,160	**11,583**	**44,153**
Region 6	1,127	1,086	1,159	1,393	1,170	**1,124**	**7,059**
Region 7	3,526	3,690	3,623	3,630	3,535	**4,192**	**22,196**
Total	**29,054**	**30,621**	**33,515**	**37,681**	**34,032**	**40,873**	**205,776**

Graph 2a. Emergency evaluations by region

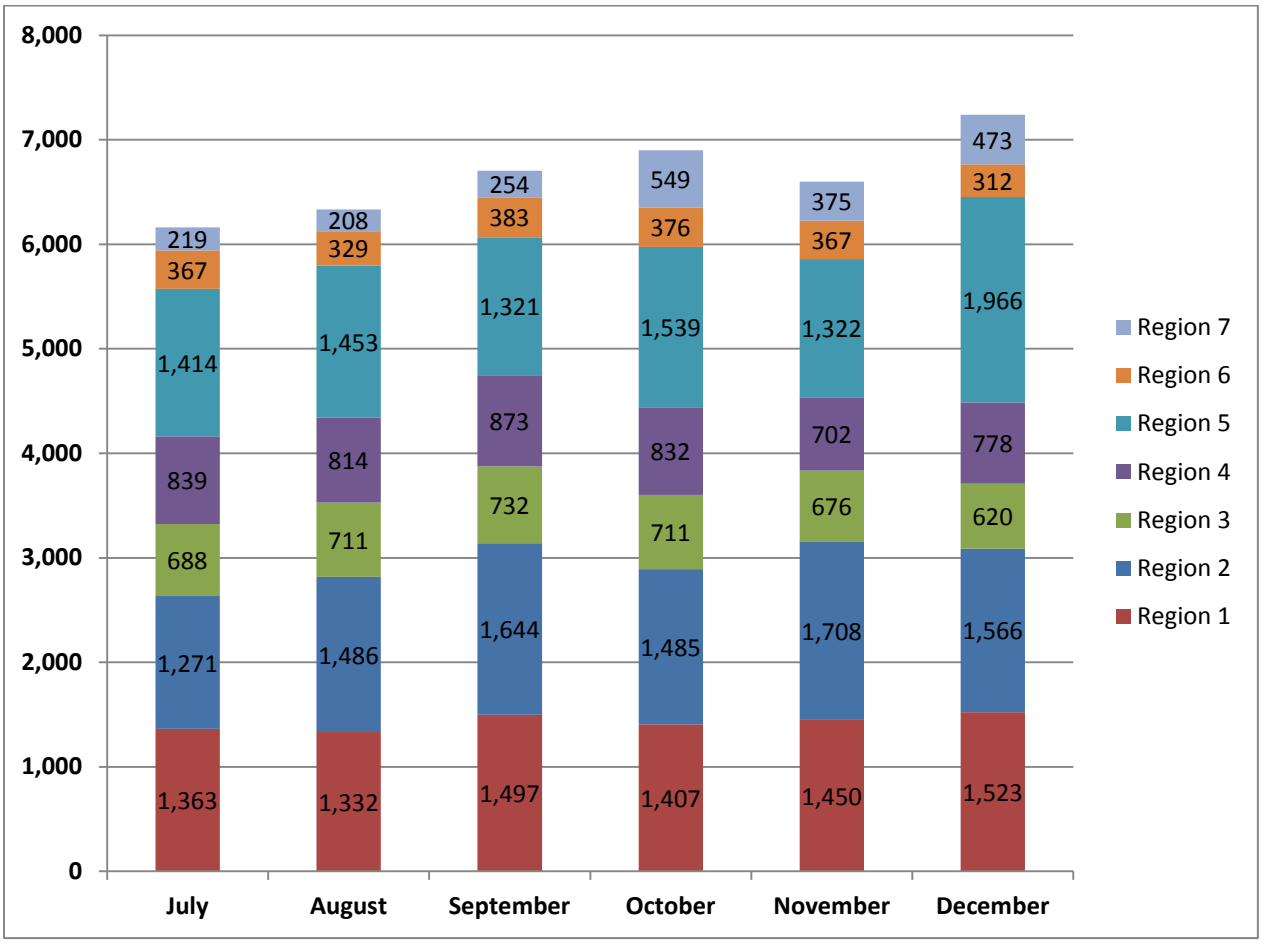


Table 2. Number of emergency evaluations (corresponds with graph 2a)

Region	July	August	September	October	November	December	Total
Region 1	1,363	1,332	1,497	1,407	1,450	**1,523**	**8,572**
Region 2	1,271	1,486	1,644	1,485	1,708	**1,566**	**9,160**
Region 3	688	711	732	711	676	**620**	**4,138**
Region 4	839	814	873	832	702	**778**	**4,838**
Region 5	1,414	1,453	1,321	1,539	1,322	**1,966**	**9,015**
Region 6	367	329	383	376	367	**312**	**2,134**
Region 7	219	208	254	549	375	**473**	**2,078**
Total	**6,161**	**6,333**	**6,704**	**6,899**	**6,600**	**7,238**	**39,935**

Graph 3a. TDOs issued by region

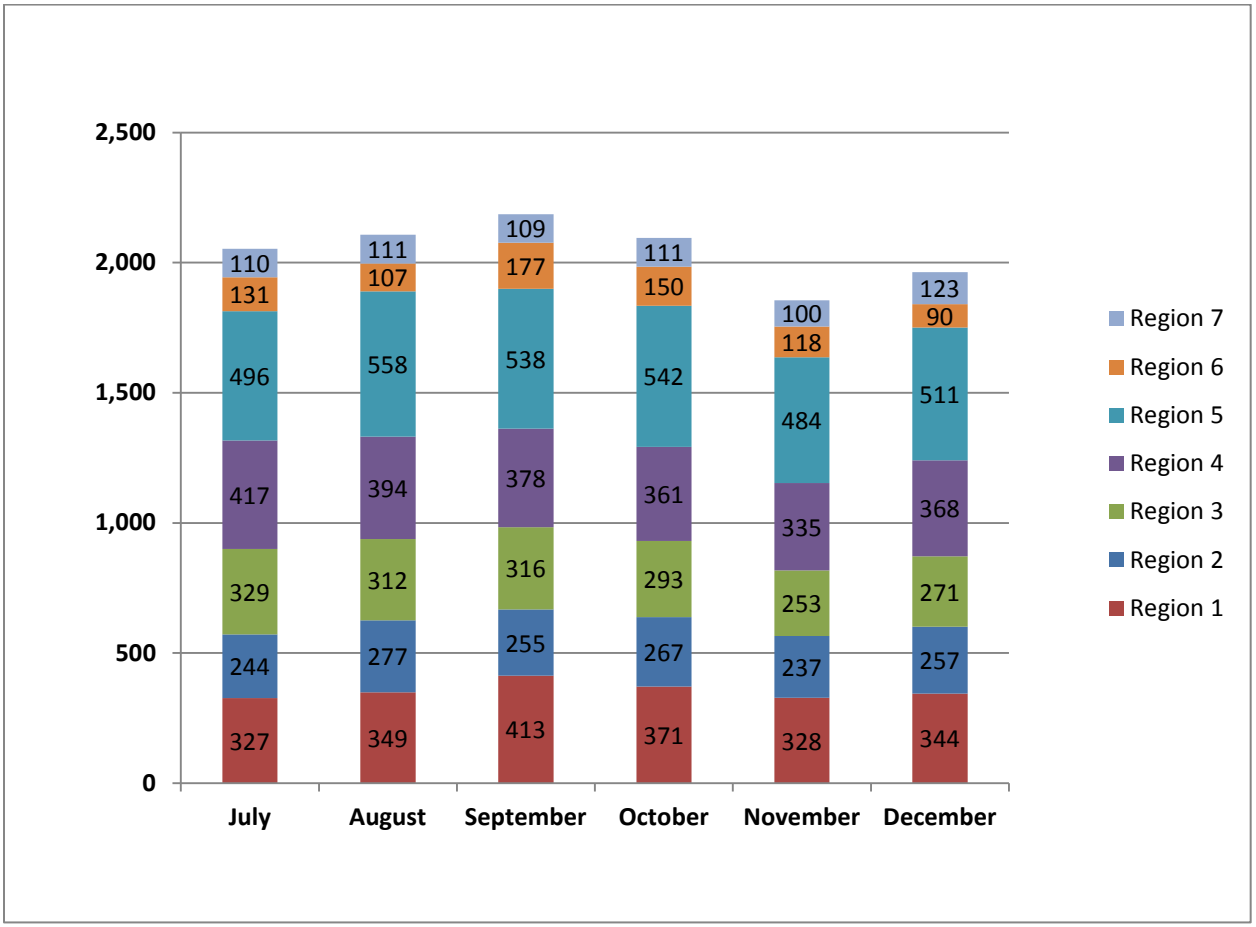


Table 3. Number of TDOs issued (corresponds with graph 3a)

Region	July	August	September	October	November	December	Total
Region 1	327	349	413	371	328	**344**	**2,132**
Region 2	244	277	255	267	237	**257**	**1,537**
Region 3	329	312	316	293	253	**271**	**1,774**
Region 4	417	394	378	361	335	**368**	**2,253**
Region 5	496	558	538	542	484	**511**	**3,129**
Region 6	131	107	177	150	118	**90**	**773**
Region 7	110	111	109	111	100	**123**	**664**
Total	**2,054**	**2,108**	**2,186**	**2,095**	**1,855**	**1,964**	**12,262**

Graph 4a. TDOs executed by region

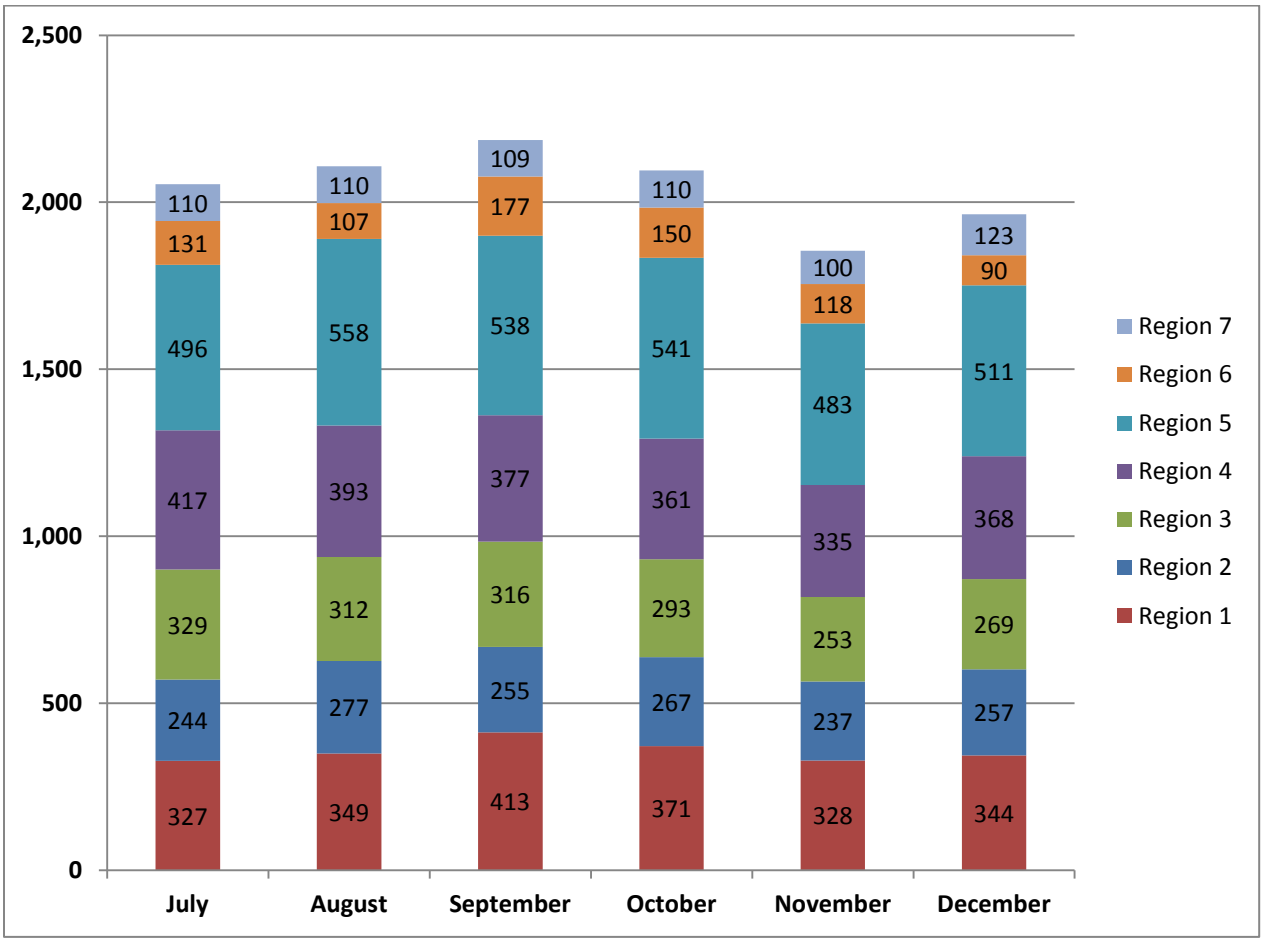


Table 4. Number of TDOs executed (corresponds with graph 4a)

Region	July	August	September	October	November	December	Total
Region 1	327	349	413	371	328	**344**	**2,132**
Region 2	244	277	255	267	237	**257**	**1,537**
Region 3	329	312	316	293	253	**269**	**1,772**
Region 4	417	393	377	361	335	**368**	**2,251**
Region 5	496	558	538	541	483	**511**	**3,127**
Region 6	131	107	177	150	118	**90**	**773**
Region 7	110	110	109	110	100	**123**	**662**
Total	**2,054**	**2,106**	**2,185**	**2,093**	**1,854**	**1,962**	**12,254**

Graph 5a. TDO admissions to a state hospital by region

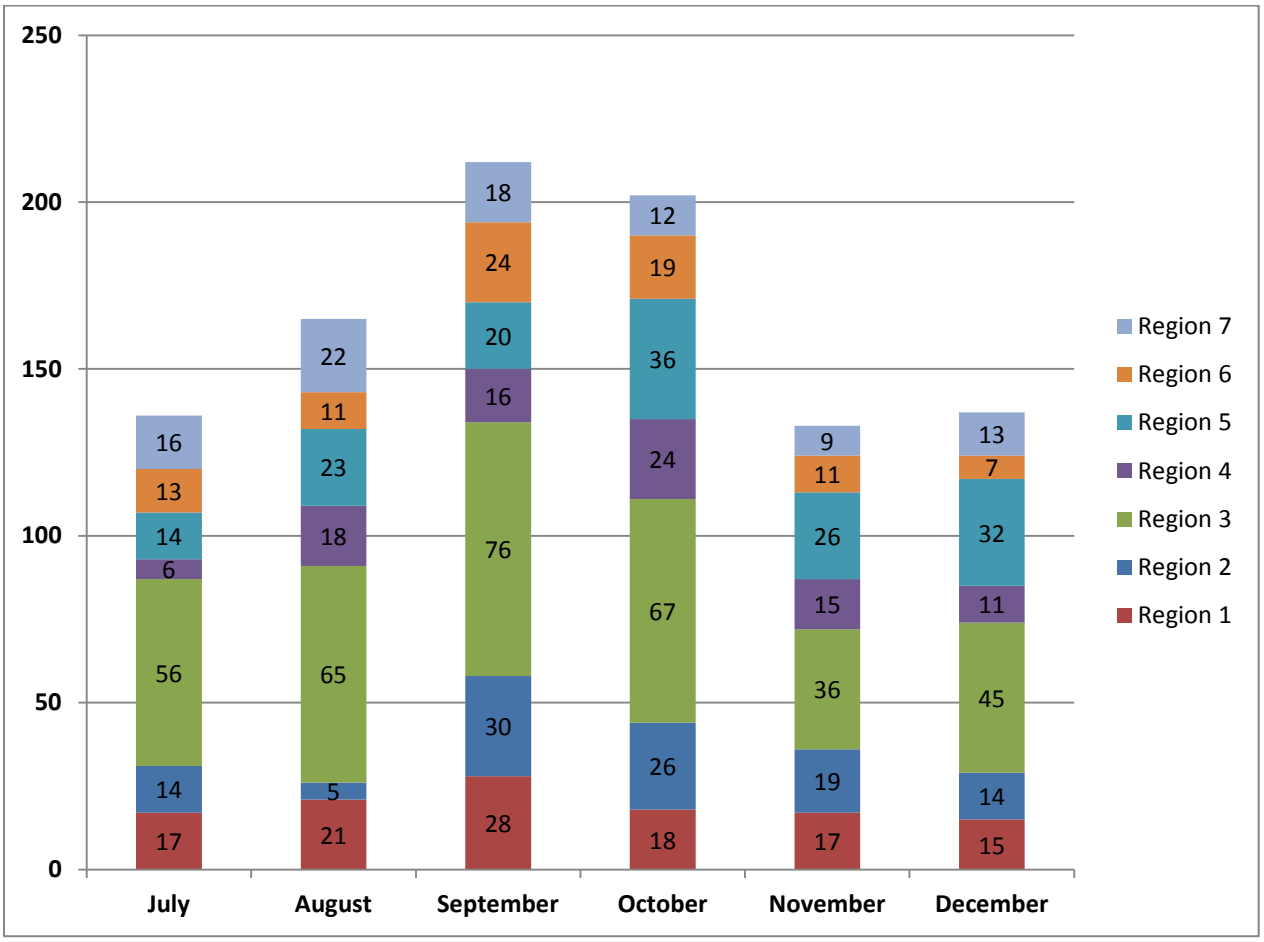


Table 5. TDO admissions to a state hospital (corresponds with graph 5a)

Region	July	August	September	October	November	December	Total
Region 1	17	21	28	18	17	**15**	**116**
Region 2	14	5	30	26	19	**14**	**108**
Region 3	56	65	76	67	36	**45**	**345**
Region 4	6	18	16	24	15	**11**	**90**
Region 5	14	23	20	36	26	**32**	**151**
Region 6	13	11	24	19	11	**7**	**85**
Region 7	16	22	18	12	9	**13**	**90**
Total	**136**	**165**	**212**	**202**	**133**	**137**	**985**

Graph 6a. State hospital admission delayed by region

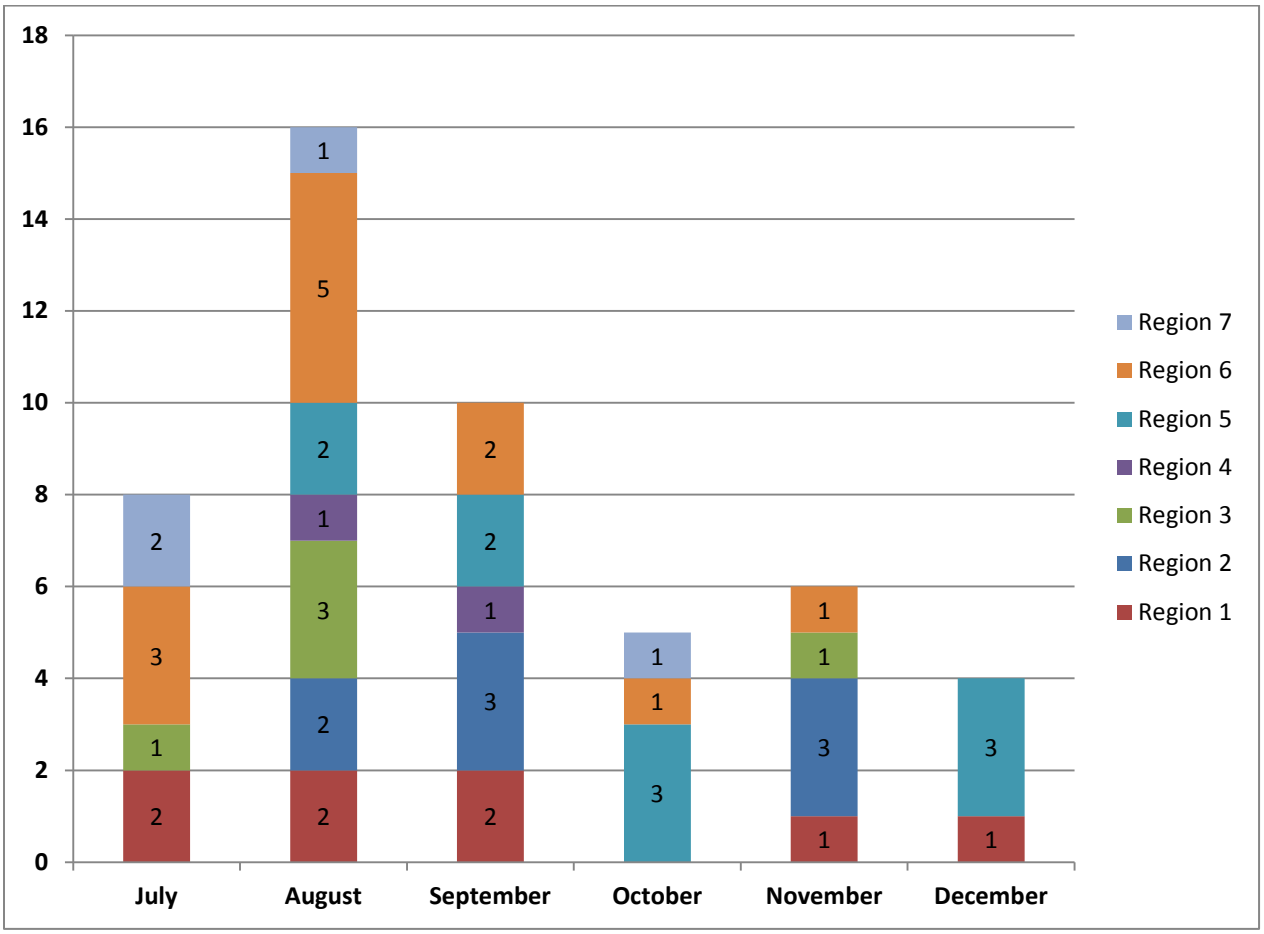


Table 6. State hospital admission delayed (corresponds with graph 6a)

Region	July	August	September	October	November	December	Total
Region 1	2	2	2	0	1	1	8
Region 2	0	2	3	0	3	0	8
Region 3	1	3	0	0	1	0	5
Region 4	0	1	1	0	0	0	2
Region 5	0	2	2	3	0	3	10
Region 6	3	5	2	1	1	0	12
Region 7	2	1	0	1	0	0	4
Total	**8**	**16**	**10**	**5**	**6**	**4**	**49**

Graph 7a. TDO executed after ECO expired by region

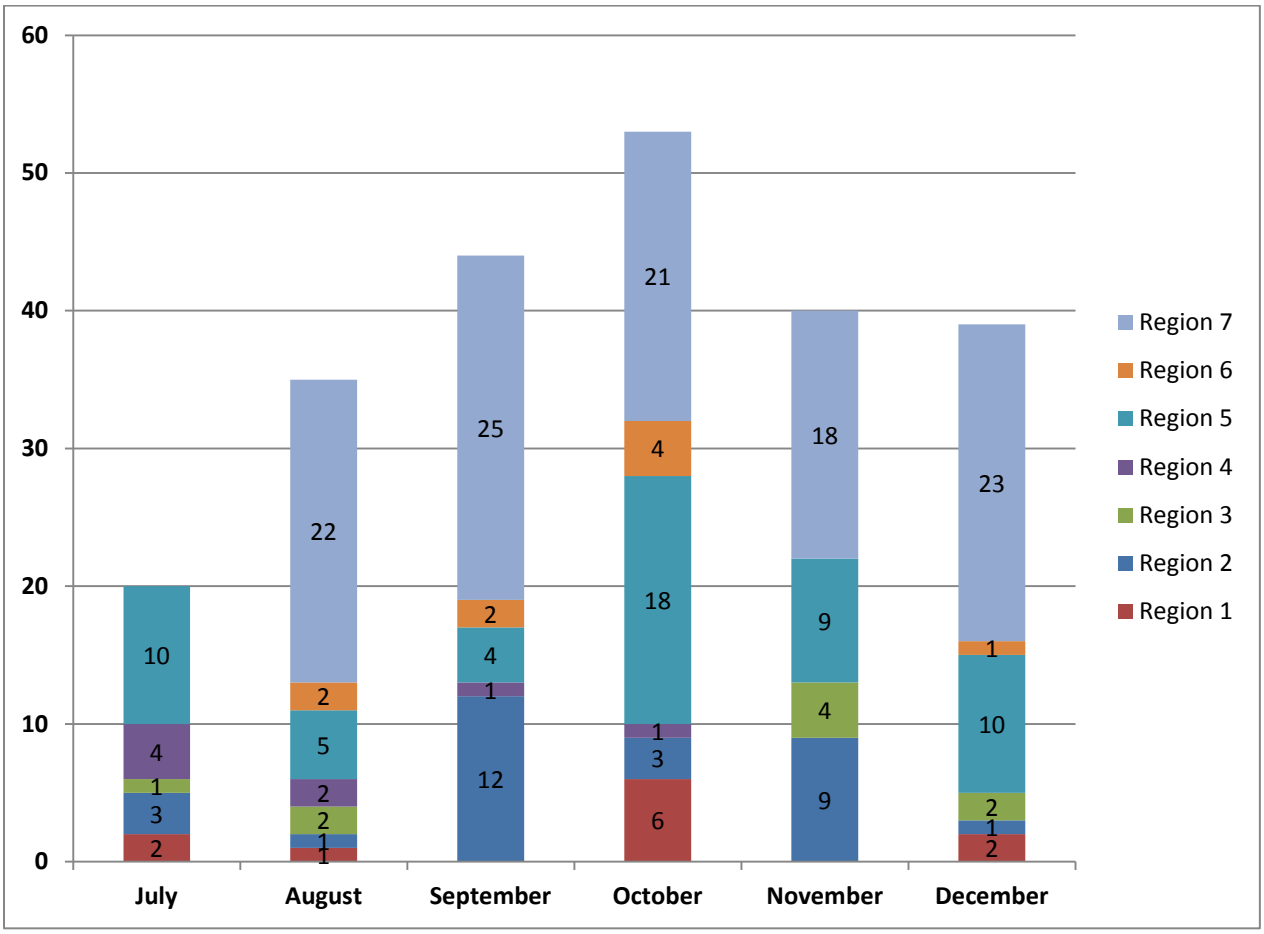


Table 7. TDO executed after ECO expired (corresponds with graph 7a)

Region	July	August	September	October	November	December	Total
Region 1	2	1	0	6	0	**2**	**11**
Region 2	3	1	12	3	9	**1**	**29**
Region 3	1	2	0	0	4	**2**	**9**
Region 4	4	2	1	1	0	**0**	**8**
Region 5	10	5	4	18	9	**10**	**56**
Region 6	0	2	2	4	0	**1**	**9**
Region 7	0	22	25	21	18	**23**	**109**
Total	**20**	**35**	**44**	**53**	**40**	**39**	**231**

Graph 8a. Transfers during temporary detention by region

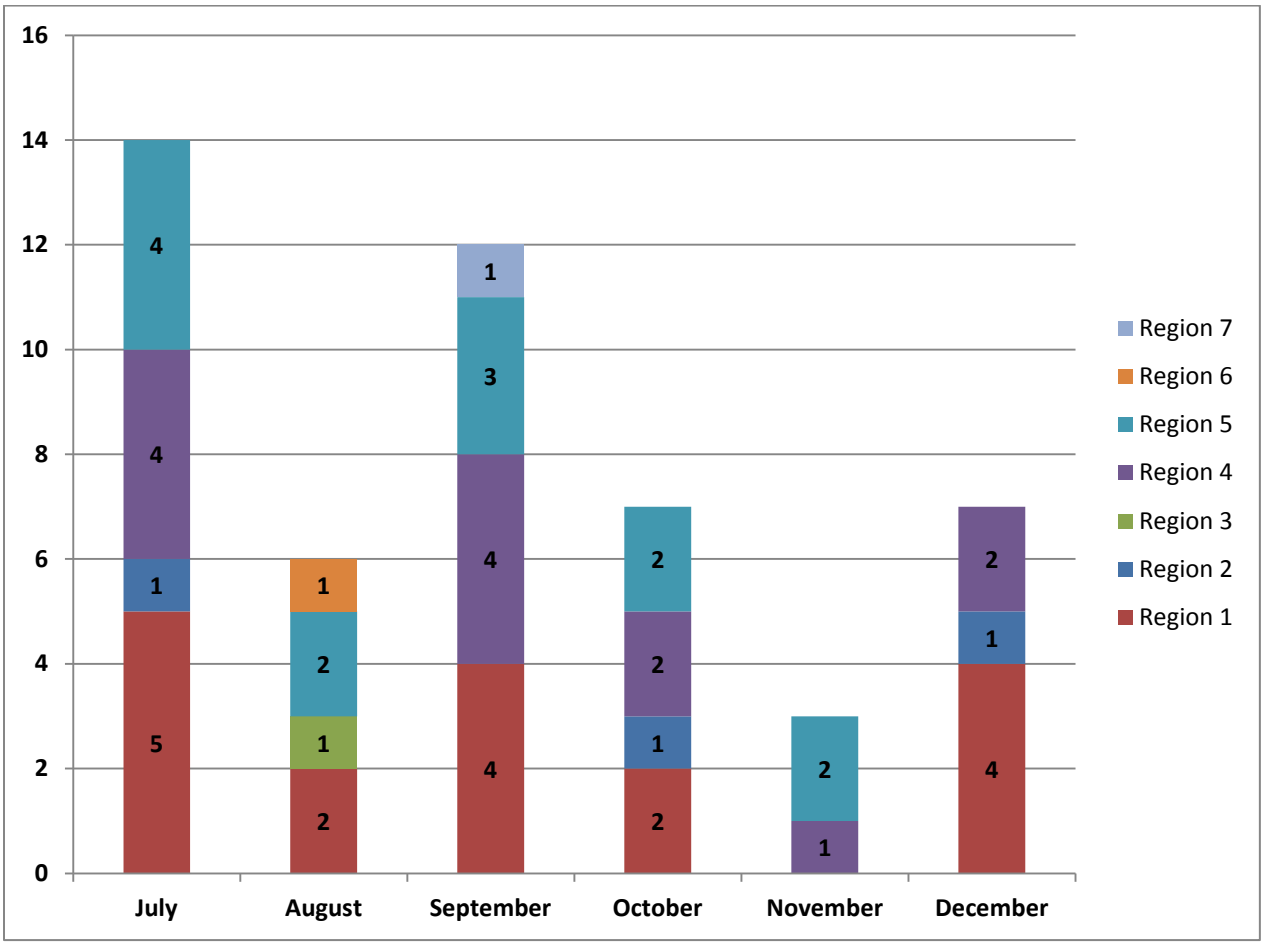


Table 8. Transfers during temporary detention (corresponds with graph 8a, pg 10)

Region	July	August	September	October	November	December	Total
Region 1	5	2	4	2	0	4	17
Region 2	1	0	0	1	0	1	3
Region 3	0	1	0	0	0	0	1
Region 4	4	0	4	2	1	2	13
Region 5	4	2	3	2	2	0	13
Region 6	0	1	0	0	0	0	1
Region 7	0	0	1	0	0	0	1
Total	**14**	**6**	**12**	**7**	**3**	**7**	**49**

Graph 9a. TDOs to state hospital without ECO by region

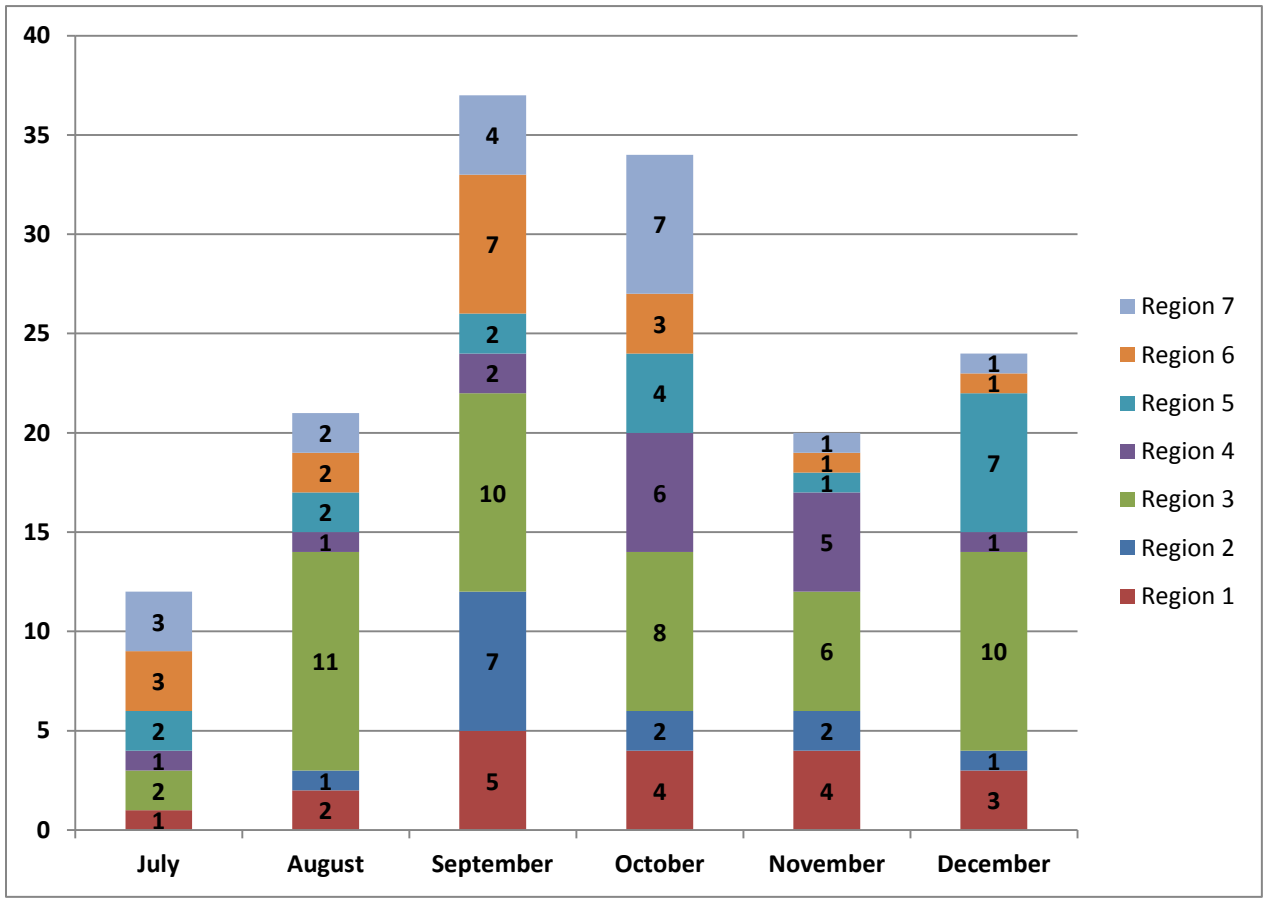


Table 9. State hospital TDOs without ECOs (corresponds with graph 9a)

Region	July	August	September	October	November	December	Total
Region 1	1	2	5	4	4	3	19
Region 2	0	1	7	2	2	1	13
Region 3	2	11	10	8	6	10	47
Region 4	1	1	2	6	5	1	16
Region 5	2	2	2	4	1	7	18
Region 6	3	2	7	3	1	1	17
Region 7	3	2	4	7	1	1	18
Total	**12**	**21**	**37**	**34**	**20**	**24**	**148**

APPENDIX D

DBHDS requires CSBs to report within 24-hours any event involving an individual who is deemed to require temporary detention for whom the TDO is not executed for any reason, whether or not an ECO was issued or in effect. These reports are sent to the DBHDS Quality Oversight Team that includes the DBHDS Medical Director, the Assistant Commissioner for Behavioral Health, the Director of Mental Health Services, and the MH Crisis Specialist. Each report contains the CSB's description of the incident and the CSB's proposed actions to resolve the event and prevent such occurrences in the future. In each case, the DBHDS Quality Oversight Team examines the report for completeness, comprehensiveness and sufficiency, and responds immediately to the CSB Executive Director if any further information is needed. In addition, the Quality Oversight team specifies additional follow up actions that are deemed necessary, requests appropriate follow up communication from the CSB, and maintains an open incident file until the incident has resolved and follow up actions have been completed.

There were three critical events of this nature during the month of December 2014. The three reported cases are summarized below. DBHDS has followed up with the relevant CSBs to gather additional information and to give to the CSB specific clinical and quality feedback about how each case was handled, what behaviors or procedures may have contributed to the event, what clinical and administrative or process issues need to be addressed in developing solutions to the problems encountered, strategies to implement with partner entities, etc. These case-driven DBHDS interventions are still ongoing at the time of this report.

Of the three cases reported in December, all involved individuals who were evaluated on a voluntary basis (i.e., the individuals were not under an ECO). Of these cases, one individual eloped from the site of the evaluation before the TDO was executed. Another remained voluntarily on a medical unit of a local hospital. Both of these individuals were subsequently detained. In the third case, the involved law enforcement officer transported the individual to his home after the TDO was executed because the officer did not know about the statute allowing a transfer of the facility of detention.

The case summaries follow.

1. The individual was evaluated by the CSB and deemed to meet the criteria for temporary detention. The CSB evaluator obtained a bed in a private psychiatric facility. The local magistrate issued a two-stop TDO to allow for medical screening at a local emergency department. While in the emergency department the individual was found to have a contagious but non-life threatening condition. When the temporary detention facility was informed of this condition, the facility decided the individual could not be managed safely on their unit. The CSB evaluator located another detention facility and informed the law enforcement officer of the change. The officer refused to transport the individual to the second facility because it was not the facility named on the TDO. The individual was then returned home and released by the officer. The CSB evaluator continued attempts to persuade the officer to transport the individual to the second facility, but ultimately had to

call a regional magistrate (local magistrate was off duty) to instruct the officer to return to the individual's home, take the individual into custody and transport the individual to the temporary detention facility identified by the CSB evaluator. The individual was transported safely to that facility.

The DBHDS Quality Oversight Team reviewed this report and recommended that the CSB follow up with local law enforcement regarding the handling of this incident. The CSB met with several law enforcement agencies in their catchment to review procedures and train officers and deputies on Virginia law relating to the emergency custody and the temporary detention process.

2. In this case the individual had been admitted to a medical hospital for medical treatment of several complex medical conditions. The CSB was contacted to assess the individual for possible involuntary psychiatric hospitalization due to reported psychiatric symptoms. The individual was refusing medications citing a desire to use only homeopathic treatment options. The CSB evaluator completed the assessment and determined the individual did not meet TDO criteria. The hospital's own mental health clinician was not willing to petition for involuntary treatment so no TDO was sought.

   The CSB was contacted again three days later to conduct another assessment, stating that the individual was now willing to seek voluntary admission to a psychiatric facility. A different CSB evaluator completed this assessment and found that the individual continued to express distrust of Western medicine and a desire to be treated with homeopathic treatments exclusively, but the individual was willing to be admitted voluntarily to a psychiatric facility. The CSB evaluator contacted ten facilities that showed beds available on the statewide Psychiatric Bed Registry. Only one facility was willing to accept the individual but stated the individual would need to be under a TDO. After seeking consultation, the CSB evaluator determined that a TDO would be justified. However, when the CSB evaluator contacted the facility again to inform them about the TDO, the facility declined the admission stating the individual's current needs were more medical than psychiatric at this time. The individual remained on the medical unit and the CSB evaluator began a statewide search for a willing facility for temporary detention.

   Several additional days passed and the individual was reassessed by another CSB evaluator who also determined that a TDO was warranted. Another statewide bed search began and no accepting facility could be found. The individual remained on the medical unit until a bed became available at a hospital within the medical facility's network and a TDO was issued.

   The DBHDS Quality Oversight Team recommended that the CSB provide additional training to CSB evaluators and to review the process of state facility notification as set forth in the

regional protocol. The CSB has completed and documented the CSB evaluators' additional training. CSB administrative and management staff met with the medical facility administration to review the incident and determine how to improve the working relationship between the medical facility and the CSB to insure that the individual's best interests are uppermost. The mental health personnel of the medical facility agreed to provide training to the medical unit staff on Virginia law governing temporary detention orders and involuntary admission. CSB and hospital administrators have agreed to meet monthly to review incidents and to build a stronger community partnership.

The DBHDS Quality Oversight Team also requested that the state facility in the catchment area work with the CSB and region to refine its notification process for individuals who are not in emergency custody and to amend its referral protocol accordingly to clarify the decision thresholds for use of the state hospital as a "last resort" facility under these circumstances. The regional protocol has been amended and posted on the DBHDS website pending final approval by the regional leadership group.

3. The individual presented voluntarily to a hospital emergency department seeking mental health services based on the recommendation of his primary care physician (PCP). The PCP had recommended that the individual seek care after making suicidal statements to the PCP earlier in the day. The individual was admitted to the emergency department and placed in an exam room in direct view of the nursing station. The individual was assessed by a CSB evaluator and was determined to meet TDO criteria due to his serious suicide risk. The CSB evaluator left the exam room to go to another part of the emergency department to conduct a search for a psychiatric hospital bed.

   Upon locating a bed the CSB evaluator returned to the exam room, but the individual was not there and the emergency department staff reported they did not see the individual leave. The ED staff as well as law enforcement officers who were present in the ED and other hospital security officers initiated a search of the ED for the individual. The CSB evaluator notified local law enforcement and the CSB Emergency Services supervisor and attempted to reach the individual's emergency contact as listed on his admitting paperwork.

   The CSB evaluator reached the individual on his personal cell phone and urged the individual to return to the ED or disclose his whereabouts so that law enforcement could be sent to bring him back to the ED. The individual provided a false location and was not found by law enforcement. The CSB evaluator requested that the magistrate issue the TDO while the search for the individual continued. The CSB evaluator and other CSB staff continued their attempts to locate the individual by working with area law enforcement.

A second TDO was issued after the initial TDO expired without being executed. Efforts to locate the individual continued. The individual's friends and loved ones did not cooperate in the search despite the CSB's concern for the individual's personal safety. The second TDO expired without locating the individual.

Several days later the individual was located and an ECO was issued. The individual was taken into custody and transported to the ED for reassessment. The individual was found to meet TDO criteria and a third TDO was issued. The individual was then safely transported to the facility of detention. Subsequently, the individual completed inpatient treatment and has been engaged with ongoing CSB mental health services on an outpatient basis.

Following initial reporting of the incident, and in consultation with the DBHDS Quality Oversight Team, the CSB initiated an internal review of the incident as it was unfolding, and also met with the local emergency department administrator's to review the incident. As a result of this meeting, the hospital's protocol for maintaining individual safety in the ED has been revised. The DBHDS Quality Oversight Team also recommended that lessons learned by this emergency department be shared with other hospital emergency departments within the region.

All three of the above incidents were reported to DBHDS in accordance with the established protocol within 24 hours. As described above, in response to these cases, DBHDS and CSBs initiated targeted interventions with the individuals involved, as well as remedial efforts with service delivery partners to mitigate risks and improve processes and care coordination. DBHDS maintains an open file of each case until all follow up issues are addressed and resolved. DBHDS is actively working with regions and CSBs to identify and address factors contributing to the problems described in this TDO exceptions report. DBHDS is also clarifying data definitions and updating reporting protocols to ensure uniformity in data collection and reduce inconsistent reporting on an ongoing basis.